



CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

Full Name:
Date of Birth: Age: Gender:
Street Address:
City: State: Zip Code:
Home Phone #: Cell Phone #:
Marital Status:
Social Security Number:
E-Mail:
Employer Name: Your Occupation:
Work Street Address:
City: State: Zip Code:
Work Phone: Ext.
Who referred you into our office?
How would you like to be notified of future appointments?
[] Home Phone [] Cell Phone [] E-Mail [] Text Message

SYMPTOMS

Briefly describe your current symptoms/present complaints:
Date your symptoms began:
Is your visit due to an accident? YES NO
What do you hope to get accomplished from your office visits?

INSURANCE INFORMATION

Who should receive the billing statements for your care?
[] Patient/Cash [] Personal Health Insurance
[] Worker's Comp (L&I) [] Auto/Personal Injury [] Medicare
[] Other

AUTHORIZATIONS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit of my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Matheny Chiropractic Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctor(s) at Matheny Chiropractic Center and whoever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature : Date :